

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 010937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2016
NAME OF PROVIDER OR SUPPLIER ASSISTED LIVING AT HARTSFIELD VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 10002 COLUMBIA AVE MUNSTER, IN 46321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: April 18 & 19, 2016</p> <p>Facility number: 010937 Provider number: N/A AIM number: N/A</p> <p>Census bed type: Residential: 84 Total: 84</p> <p>Census payor type: Private: 84 Total: 84</p> <p>Sample: 7</p> <p>Assisted Living at Hartsfield Village was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p> <p>QR was completed by 99993 on 04/21/16.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE